CONTRACT # _____

Between
The North Carolina Department of Health and Human Services
And

_____

FEDERAL TAX ID # _____

1.0 Parties to the Contract

This Contract is entered into by and between the North Carolina Department of Health and Human Services, an agency of the State of North Carolina, hereinafter referred to as the "Department" or "DHHS" and the _____, a political subdivision of the State of North Carolina, hereinafter referred to as the "Local Management Entity" or "LME".

2.0 Terms of Contract

The term of this contract shall be for a period, commencing December 1, 2007 and ending June 30, 2008.

3.0 Contract Documents

The following documents are incorporated herein by reference:

(1) Attachment I – Scope of Work
(2) Attachment II – Performance Measures
(3) Attachment III – Financing
(4) Attachment IV – Data Use Agreement

In the event of a conflict in terms between the Contract Documents, the documents will be accorded precedence in the following order: the Contract, Attachment I - Scope of Work, Attachment II – Performance Measures, Attachment III – Financing, and Attachment IV – Agreement to Share Data. Portions of this Contract relating to Medicaid financing and Medicaid services may require approval by the federal Centers for Medicare and Medicaid (CMS). Nothing in this Contract or the referenced Attachments shall be construed to create an entitlement to services purchased with State or State-allocated federal funds.

4.0 Assignment

No assignment of the LME's obligations or the LME's right to receive payment hereunder shall be permitted. However, when assignments are made pursuant to changes in governance or counties participating in an LME, assignments may be made with prior written approval of DHHS, which approval will not be unreasonably withheld. Upon such approved assignment, the assigned contract will be deemed a novation.

5.0 Subcontracting

The LME may subcontract the functions contemplated under this Contract. The LME shall be responsible for the performance of any subcontractor. The LME shall establish procedures for the oversight, monitoring and evaluation of subcontractors to ensure accurate reporting and appropriate use of State funds.

6.0 Beneficiary

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood

and agreed that the enforcement of the terms and conditions of this Contract and all rights of action relating to such enforcement, shall be strictly reserved to the Department and the LME. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Department and LME that any person or entity, other than the Department or the LME receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

7.0 Entire Agreement

This Contract and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements, with the exception of the DMA Provider Agreement between the LME and DMA and the contracts between the LME and the individual institutions of the DMH/DD/SAS.

8.0 Availability of Funds

The parties to this Contract agree and understand that the payment of the sums specified in this Contract is dependent and contingent upon the appropriation, allocation and availability of funds for this purpose to DHHS and the LME.

9.0 Responsibilities of the Department

The responsibilities of the Department are as follows:

(1) Certify the LME's Local Business Plan (LBP), prepared in accordance with DHHS requirements and GS 122C-115.2(c);
(2) Reimburse the LME for the costs of functions and activities as described in Attachment III; provided that DHHS shall reduce the LME's administrative funding by 10% annually if the LME does not comply with the catchment area requirements of G.S. 122C-115; and provided further that nothing contained herein shall limit the Secretary's authority to suspend funding pursuant to G.S. §§122C-124.1 and 147;
(3) Monitor the LME for compliance with the terms of this Contract and publish individual and comparative reports regarding the LME's performance under this contract;
(4) Notify in a timely manner the LME of changes in covered services or conditions of providing covered administrative services;
(5) Administer a Medicaid fair hearing process consistent with State and federal requirements;
(6) Collaborate with the LME on quality improvement activities, fraud and abuse issues, and other activities that impact the services provided to recipients;
(7) In accordance with Attachment IV, share Medicaid paid claims data and authorization data on a client specific basis with the LME;
(8) Establish system procedures and expectations for DHHS and its contractors (e.g., ValueOptions, EDS) for the execution of fund transmission to LMEs in accordance with the prompt-pay requirements for LMEs;
(9) Except when business conditions dictate (changes in federal law regulation or policy; changes in state law or regulation, or business conditions which necessitate a more expedient implementation) adherence to a less than 90 day implementation timeline, DHHS will notify LMEs of policy or procedure changes 90 days prior to effective date of change;
(10) All other responsibilities contained in this Contract;
(11) Review the contract annually.

10.0 Responsibilities of the LME

The responsibilities of the LME are as follows:

(1) Serve as a Local Management Entity (LME) for public mental health, developmental disabilities and substance abuse services in the LME's geographic territory;

(2) Update and implement a Local Business Plan (LBP) certified by DHHS, perform the functions described in the LBP in accordance with its terms and the terms of this Contract;
(3) Perform the functions outlined in Attachment I - Scope of Work;
(4) Be wholly responsible for the work to be performed and for the supervision of its employees. The LME represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Agreement. Such employees shall not be employees of the Department, for the purpose of this contract;
(5) Prioritize State and non-Medicaid federal funds allocated for services under this contract for mental health, developmental disabilities and substance abuse services for severely disabled and economically disadvantaged individuals in the catchment area in accordance with DHHS Target Population categories;
(6) Submit to the Department all plans, reports or documents required by statute or duly adopted regulation, state or federal funding agreements, DHHS policy and this Contract;
(7) Monitor subgrantees for compliance with the terms of subcontracts and ensure that subgrantees comply with all reporting requirements of the LME;
(8) Allow the Department unrestricted access to all public meetings, activities, and documents pertaining to the fulfillment of functions or activities funded by this contract;
(9) Contract with any Medicaid provider agency for billing purposes only when that agency does not have the ability to directly enroll with the DMA;
(10) Subject to funds availability implement the approved LME crisis plan;
(11) All other responsibilities contained in this Contract
(12) Submit required cost reports (if applicable)

11.0 Accreditation for Management Functions

For those LMES who have not achieved national accreditation, each LME will make a decision regarding the choice of the national accreditation body during the term of this contract.

12.0 Accreditation for Direct Services

If the LME has been approved to provide direct services to consumers, the LME shall achieve service delivery accreditation consistent with the accreditation required by DHHS policy.

13.0 Notice of Certain Reporting and Audit Requirements

The LME shall use or expend the funds available under this contract only for the purposes for which they were appropriated by the General Assembly or received by the State. State funds include federal funds that flow through the State. The LME is subject to the requirements of OMB Circular A-133 and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.

The LME shall furnish to the State Auditor, upon his/her request, all books, records and other information that the State Auditor needs to fully account for the use and expenditure of state funds.

If the LME disburses or transfers state funds to other organizations other than for the purchase of goods or services, the LME will require the recipient(s) to file reports and statements required in GS § 143C-6.22 and 6.23 and the State Auditor's Audit Advisory # ADV-2005-001.

If any funds available to the LME under this contract are passed through the LME to another organization as financial assistance, those funds will require monitoring in accordance with OMB Circular A-133 and G.S. §§ 143C-6.22 and 143-6.23. The LME shall establish procedures for the oversight, monitoring and evaluation of subgrantees to ensure accurate reporting and appropriate use of State funds.

14.0 Record Retention

Both parties shall retain records at their own expense in accordance with applicable requirements. At a minimum, parties will maintain all grant records for a period of five years after the grant closes or until all audit exceptions, litigation, claims or other official action involving the records have been resolved, whichever is longer.

In order to protect documents and public records that may be involved in DHHS litigation, the Department will notify the LME when documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller's Office.

LMEs are also subject to the requirements of the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3).

The LME shall facilitate and monitor the compliance of its providers with applicable records retention and disposition requirements.

When an LME dissolves, the successor organization is obligated to assume responsibility for the records of the dissolved LME for the duration of the retention schedule for those records per the Records Retention and Disposition Schedule for State and Area Facilities (APSM 10-3). This includes client records, administrative records and other records covered by the retention schedule. The successor LME has the option of scanning the records and disposing of the paper copies or renting storage space and retaining the records in storage. These records can be disposed of when the retention schedule for the records has been met. Records which have met the retention schedule shall be destroyed if these records are not subject to audit, investigation, or litigation.

15.0 Liabilities and Legal Obligations

Each party hereto agrees to be responsible for its own liabilities and that of its officers, employees, agents or representatives arising out of this Contract.

16.0 Compliance with Laws

The LME and the Department shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

17.0 Amendment

All amendments shall be made in written form and executed by duly authorized representatives of the Department and the LME. This contract may not be amended orally or by performance. DHHS may unilaterally amend the terms of this Contract if it removes any one or more of the LME's functions pursuant to Chapter 122C of the North Carolina General Statutes.

18.0 Choice of Law

The laws of the State of North Carolina shall govern and control this Contract. The parties agree that in litigation initiated by the LME, related to matters concerning this Contract, venue for legal proceedings shall be Wake County, North Carolina. The parties further agree that in any action initiated by DHHS against the LME under or arising from or involving the validity, construction, interpretation or enforcement of this contract, venue will be appropriate in the County where the LME's primary administrative office is located.

19.0 Federal Certifications

The LME agrees to execute the following federal certifications:

(1) Certification Regarding Lobbying;
(2) Certification Regarding Debarment;
(3) Certification Regarding Drug-Free Workplace Requirements;
(4) Certification Regarding Environmental Tobacco Smoke.

20.0 Severability

In the event that a court of competent jurisdiction holds that a provision or requirement of this Contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent that it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this Contract shall remain in full force and effect.

21.0 Confidentiality

Any medical records, personnel information or other items exempt from the NC Public Records Act or otherwise protected by law from disclosure given to the LME under this contract shall be kept confidential and not divulged or made available to any individual or organization without the prior written approval of DHHS except as otherwise provided by law.

22.0 Termination

a. For Convenience: This agreement may be terminated for convenience at any time by the mutual written agreement of the parties without additional liability to either party.

b. For Cause: Pursuant to G.S. § 122C-125, this contract is terminable for cause by DHHS. Additionally, pursuant to Chapter 122C of the North Carolina General Statutes, DHHS may remove certain duties and responsibilities from the LME and may suspend funding to the LME and no provisions herein shall be construed to diminish, lessen, limit, share, or divide the authority of DHHS or the Secretary of DHHS to so act.

23.0 Secretary's Authority Undiminished

Certain functions delegated to the LME pursuant to this Contract are the duty and responsibility of DHHS as the single state agency responsible for the administration of the North Carolina Medicaid program and as the grantee of federal block grant funds such as the Mental Health Block Grant, the Substance Abuse Prevention and Treatment Block Grant and the Social Services Block Grant. The parties understand and agree that nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Secretary of DHHS to perform any of the duties assigned to the DHHS or its Secretary by the North Carolina General Statutes, the State Medicaid Plan, the Medicaid laws and regulations, the terms and conditions of the block grants and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by DHHS to reimburse the LME for any of its contractual duties

24.0 Originals

In witness whereof, the LME and Department have executed this Agreement in duplicate originals, one of which is retained by each of the parties.

25.0 Notifications

The persons named below shall be the persons to whom notices provided for in this Contract shall be given. Either party may change the person to whom notice shall be given. All notices shall be deemed received only when they are actually received.

For the Department of Health and Human Services:

Michael Moseley, Division Director
325 N. Salisbury St
3001 Mail Service Center
Raleigh, NC 27699-3001
Phone (919) 733-7011 Fax (919) 508-0951

For the LME:

_____ ***(Enter name and title)***
_____ ***(Enter Agency's name)***
_____ ***(Enter Street Address)***
_____ ***(Enter P.O. Address)***
_____ (***Enter City, State, and Zip Code)***
Phone (___) ___-____ Fax (___) ___-____ ***(Enter numbers)***

26.0 Signature Warranty

Each individual signing below warrants that he or she is duly authorized by the party to sign this Contract and to bind the party to the terms and conditions of this Contract.

BY: _____ Witness: _____
Name

TITLE: _____

LME: _____

DATE: _____

North Carolina Department of Health and Human Services

BY: _____
Secretary or Designee

DATE: _____

ATTACHMENT I
SCOPE OF WORK

The LME shall perform all Local Management Entity (LME) functions in accordance with DHHS requirements. The functions include:

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations;
(6) Access, Screening, Triage and Referral;
(7) Service Management
(8) Consumer Affairs and Customer Service;
(9) Quality Management

1.0 General Administration and Governance

1.1 Area Board and Consumer and Family Advisory Committee (CFAC) Relationship

At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and the governing board shall execute an agreement that identifies the roles and responsibilities of each party, channels of communication between the parties, and a process for resolving disputes between the parties.

1.2 Area Board Meetings

The LME shall ensure that the Board meets the composition requirements of G.S. § 122C-118.1 and shall meet at least six (6) times per year. The LME shall provide an annual training and sufficient support to ensure that the Board actively reviews regular reports on finances, local performance, service utilization, customer service, unmet local service needs and provider capacity. Unless delineated elsewhere, each LME shall define training needs.

1.3 Consumer and Family Advisory Committee (CFAC) Meetings

The LME shall provide sufficient financial and administrative support to ensure that the CFAC shall meet the composition requirements of G.S. § 122C-170 and shall meet at least six (6) times per year. The LME shall provide sufficient training on the LME business plan, budget, and other topics to support the CFAC's review of regular reports on finances, local performance, and customer service on a regular basis. Unless delineated elsewhere, each LME shall define training needs.

1.4 Area Director Evaluation

The Area Board shall ensure that its annual evaluation of the Area Director includes an evaluation of the criteria established by the NC Secretary of DHHS in Communication Bulletin # 20, dated June 1, 2004 which referenced 122C-121(d).

1.5 Capacity and Competency

The LME shall have an administrative and organizational structure adequate to perform the functions required under this contract. The LME shall employ qualified personnel sufficient to carry out the requirements of this contract. This includes ensuring sufficient numbers of staff

meeting the CMS definition of Skilled Professional Medical Personnel (SPMP) and clinical staff competent in all three disability areas. The LME shall document SPMP status, including both individual staff qualifications and area of work assignment, to ensure Federal Financial Participation (FFP) at the enhanced 75% FFP rate. The LME shall ensure that all staff has the training, education, experience, licensing or certification appropriate to their position and responsibilities.

1.6 Conflict of Interest

The term "conflict of interest" refers to situations in which financial or other personal considerations may adversely affect, or have the appearance of adversely affecting, an individual's professional judgment in performing any activity or duty in connection with this contract. The LME, its Board of Directors, advisory committees, employees, volunteers, agents and contractors shall refrain from participation in clinical or administrative activities or decisions in which there is or may be a conflict of interest.

2.0 Business Management and Accounting

2.1 Management of State Service Funds

The LME shall establish processes and procedures that ensure that funds are available to reimburse providers for legitimately authorized, provided, and billed services. This includes estimating the percentage of authorized services that will be delivered so that only those funds that will be spent are encumbered. The LME shall use the standardized, statewide contract for purchasing services from providers and shall comply with the statewide claims processing requirements.

2.2 Financial Records

In addition to meeting all applicable state and federal statutory and regulatory requirements, the LME shall comply with applicable Generally Accepted Accounting Principles. The LME shall maintain up-to-date and accurate accounting records for accounts payable and receivable. The LME shall submit to its Board a monthly finance report that includes an income statement and except for single counties a balance sheet. The LME shall submit other financial information to its Board, the boards of county commissioners, county managers/finance officers, CFAC and DHHS as set forth in G.S. 122C.

2.3 Contracting for Service Delivery

All contracts between the LME and its providers shall be based upon the DHHS provider contract template. All provider contracts must specify that the provider shall conform to the provisions of this Contract and comply with all applicable federal and state laws, regulations, and policies. No provider contract may contain a covenant-not-to-compete. All provider contracts shall be in writing. The LME shall retain one fully executed original of each provider contract. The LME shall make provider contracts available for the Department's inspection and copying within two working days after it receives the Department's written request. The LME shall not require directly enrolled providers of Medicaid services to sign a provider contract except for those providers who are required to bill certain Medicaid services through the LME. The LME shall not contract with any provider that has been debarred, suspended or otherwise lawfully prohibited from participation in any federal or state government procurement activity. Pursuant to Attachment III, 3.0, state funds may only be used to purchase services that conform to state-approved service definitions.

3.0 Information Management

3.1 Information Technology Infrastructure

The LME must have the ability to send files in standard Electronic Data Interchange (EDI) format. All electronic Protected Health Information (PHI) must be encrypted. The LME's IT infrastructure shall be fully compliant with the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; the HIPAA Privacy and Security regulations in 45 CFR Parts 160, 162, and 164; and the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records in 42 CFR Part 2. The LME must have an internet connection and browser capabilities as well as file sharing capabilities with File Transfer Protocol (FTP) Software.

3.2 Consumer Information

The LME shall ensure that providers submit consumer information to the LME in a timely manner. The LME shall maintain accurate and up-to-date consumer information and eligibility records in a manner which protects the privacy rights of consumers. The LME shall request and record consumer social security numbers only when it is imperative for the performance of that agency's duties and responsibilities as prescribed by law (G.S. § 132-1.10) The LME shall submit timely consumer screening, admissions and eligibility information to DHHS, as specified in DHHS policy, including additions, deletions, and changes in consumer status.

3.3 Analysis of Data Provided by DHHS

The LME shall analyze and process service authorization and claims payment data received from DHHS to inform management decision-making in areas including: identification of high cost/high need consumers; provider billing patterns and trends; utilization of various services in the service array; identification of gaps in the service array; consumer movement among providers and other areas approved in Attachment IV - Data Use Agreement.

3.4 Website

The LME shall maintain a web site on the Internet that includes current and accurate information on how consumers and families may access services in the catchment area. The home page shall identify a toll free access number and a toll free customer service number within the catchment area.

4.0 Claims Processing

4.1 Provider Billings Made Through the LME

All payments to providers shall be provisional and subject to review and audit for their conformity with DHHS requirements and those of any applicable subcontract.

a. State Funded Services

For services for which Medicaid reimbursement is not available but which are paid with State only appropriated funds, the LME shall process and adjudicate provider billings for state funded services filed in accordance with the LME's contract with the provider. If the provider bills within sixty (60) days of providing a service, the LME will pay claims in accordance with the DMH/DD/SAS prompt pay requirements set forth as follows: within eighteen (18) calendar days after the LME receives a claim from a provider, the LME shall either (a) approve payment of the

claim, (b) deny payment of the claim, or (c) determine that additional information is required for making an approval or denial. If the LME approves payment, the claim shall be paid within (30) calendar days thereafter.

The LME shall disallow claims for state funded services in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect or untimely. Any claim disallowed shall be returned to the provider with an explanation for the disallowance. The LME shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. The LME shall cooperate with its contract providers in the prompt reconciliation of disallowed billings.

State funded services which are similar to services available to Medicaid recipients through the North Carolina Medicaid State Plan, shall be reimbursed at the same reimbursement rate that is utilized for the similar Medicaid service.

b. Medicaid Funded Services

For Medicaid services billed by providers through the LME, ("pass through billing") claims shall be honored for up to twelve (12) months after the date of service. Medicaid funds paid to the LME on behalf of a provider must be forwarded to the provider within fifteen (15) business days after receipt of payment from EDS. The LME will not be liable for pass through billing Medicaid claims that may be disallowed.

4.2 First and Third Party Payments

The LME shall work with its providers to pursue all applicable first and third party payments for services in order to maximize the usage of public resources. In the event that a consumer has third party coverage or is determined to be able to pay any portion of the cost of services in accordance with G.S. § 122C-146, the LME shall coordinate benefits so that costs for services otherwise payable by DHHS are avoided or recovered from a liable first or third party payer. The LME's claims system shall include appropriate edits for coordination of benefits and third party liability.

The LME or its provider contractors may retain any first or third party revenue obtained if both of the following conditions exist:

(1) Total collections received do not exceed the total cost of services for all persons served, and
(2) State and federal law does not require the state to recover first and third party payments from the LME.

The LME shall obtain, or require its State contracted providers to obtain, all relevant payer information from each consumer to be served, his or her guardian and/or family. This information should be collected at the consumer's first encounter with the LME or its contract provider, but no later than the submission of the first claim to service. The LME shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information.

5.0 Provider Relations and Support

5.1 Assessment of Adequacy of the Provider Community

The LME shall assess community need and provider capacity on an annual basis (during the third quarter of the contract) and update on a quarterly basis. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, and the number and variety of providers for each service. The assessment shall include input from consumers, families, and community stakeholders. In evaluating the adequacy of the provider community the LME shall consider issues such as the cultural and linguistic competency of existing providers. The assessment shall also measure the availability of providers willing to participate in community emergency response efforts, such as providing services in temporary housing shelters in the event of a natural disaster which triggers an evacuation. The LME shall report the results of the annual assessment and quarterly updates to the Board and CFAC. The LME shall demonstrate that it is engaged in development efforts to address service gaps identified in the assessment.

In addition, the LME shall assess community need and provider capacity for children's services within the LME catchment area. The LME shall contract with a sufficient number of service providers to ensure that children receive services in settings which are more likely to maintain or develop positive family and community connections.

5.2 Choice of Providers

The LME shall ensure that consumers eligible for Medicaid will have freedom of choice of providers. For State services, consumers will have a choice of at least two providers for every service, except for those services with very limited usage.

5.3 Provider Manual

The LME shall develop and maintain a Provider Manual that informs providers and potential providers of the LME and DHHS processes, procedures, deadlines, and other requirements. The manual shall contain --- or refer providers to --- consumer rights information, service definitions, documentation and billing requirements, medical records requirements, consumer confidentiality and HIPAA privacy protections, etc.

5.4 Endorsement

The LME shall perform provider endorsement activities in accordance with the policies, processes, and timeframes outlined in the DHHS Provider Endorsement policy. The LME shall use the standard Memorandum of Agreement provided by DHHS when it endorses a provider to provide Medicaid-funded services. The LME shall require corrective action and may remove endorsement from providers that fail to provide required data to the LME in a timely manner or that:

(1) Fail to provide acceptable services;
(2) Fail to comply with state and federal documentation requirements;
(3) Fail to maintain licensure, if applicable;
(4) Are determined not to have been eligible for endorsement in the first place.
(5) Fail to adhere to the Medicaid Provider Agreement; or
(6) Fail to comply with DHHS policy and rules found in 10A NCAC 27G:

5.5 Provider Monitoring

The LME shall monitor providers in accordance with DHHS policy and applicable statutes. Such monitoring shall not duplicate regulatory authority or functions of agencies of the Department. Monitoring shall include determining providers' progress in achieving national accreditation, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting and rights protection requirements, meeting defined quality criteria, adherence to evidence based practices in the delivery of services and compliance with DHHS documentation requirements. Once published, the LME shall use a standard DHHS risk assessment protocol to determine the intensity of monitoring providers.

The LME shall assure a stable and high quality provider system in the LME's catchment area. The LME shall monitor providers to ensure that they remain in substantial compliance with endorsement criteria following their endorsement. When requested the LME shall monitor a provider's compliance with a Plan of Correction for Medicaid service reviews performed as an ongoing function of monitoring and endorsement reviews, or of reviews performed at the State and then submitted to the LME.

When monitoring provider compliance with Plans of Correction the LME shall conform to protocols established by the Secretary of DHHS.

5.6 Technical Assistance to Providers

The LME shall render technical assistance to providers on LME-specific policies, procedures, and requirements and DHHS policies and communications. The LME shall train providers to develop and implement appropriate crisis response systems for consumers who access emergency services. The LME shall help providers develop or improve their quality improvement activities. The LME shall help providers locate appropriate sources of technical assistance or training if the LME is unable to provide the needed assistance or training.

In order to foster a stable and high quality provider system, the LME shall offer technical assistance to providers to assist them in navigating the MH/DD/SA system. The LME shall provide guidance regarding the requirements and expectations of the State MH/DD/SA system and LME protocols. The LME may offer any technical assistance that serves the purpose of assuring an adequate supply of providers for consumers in the LME's catchment area. The LME is not required to provide any technical assistance that would be considered a normal operational procedure of a service provider. The LME shall not be required to provide technical assistance to a provider who has not assimilated previous technical assistance into its provider infrastructure.

5.7 Provider Complaints

Pursuant to G.S. 122C-151.3, the LME shall establish written procedures for local level informal dispute resolution with providers. If the local level informal appeals process does not resolve the complaint to the provider's satisfaction, the provider may appeal the issue to the State MH/DD/SA Appeals Panel. The LME shall respond to complaints from providers in a timely manner.

The LME shall interact with the DMA or DMA's contractor, as necessary, to resolve issues involving Medicaid services authorizations. Upon request of DHHS, the LME shall make available the appropriate licensed clinicians for resolution of such issues.

6.0 Access, Screening, Triage and Referral

6.1 Telephonic Access

The LME shall provide toll free access lines to its entire catchment area. The toll free telephone number shall be widely disseminated throughout the catchment area through written and broadcast public service announcements, and by including the number prominently in all LME publications and on the LME website.

The LME shall ensure that the toll-free access line is staffed by individuals that meet the definition of qualified professionals. Trained licensed clinicians that meet the Skilled Professional Medical Personnel (SPMP) qualifications set forth in 42 CFR 432.50(d) will be on site for consultation. A 24/7/365 toll free access line will also be available which will feature TTY capabilities for individuals with a hearing impairment and foreign language interpretation at no cost to the caller. When calling the access line, the consumer shall not be required to navigate an automated calling menu.

The LME telephonic access line staff and/or emergency response staff shall have access to the crisis plans if submitted by providers, of consumers currently actively receiving services in their home LME's catchment area in order to expedite crisis services. The LME staff shall have the ability to schedule appointments within 24 hours of initial contact.

6.2 Screening

The LME shall ensure that consumers who present in person or who contact the toll free access line are screened, using the uniform screening tool issued by DHHS. Screening shall include presumption of target population eligibility for state funds. Screening shall also include an assessment of the urgency of the consumer's needs.

6.3 Triage and Referral

The LME shall refer consumers to the providers of their choice, subject to the following access standards:

(1) Consumers experiencing an emergency are able to access emergency services through the LME and receive face to face services within two hours of the request for service.
(2) If the consumer need does not constitute an emergent (immediate) situation, but is nonetheless urgent (an urgent need is a consumer who presents moderate risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) rather than routine, the LME shall refer consumers to a provider capable of delivering face-to-face services within 48 hours of the request for services;
(3) The LME shall refer consumers with a routine need (a routine consumer presents with mild risk or incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to mh/dd/sa problems) for service to a provider capable of delivering face-to-face services within 10 working (14 calendar) days of the request for services.

6.4 Access to State Operated Facilities

A single entry mechanism shall be in place for admission to and discharge from State operated institutions. The LME shall comply with the DHHS bed-day allocation plan.

The LME Director shall serve as the designee of the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services in approving admission to State

psychiatric hospitals in accordance with G.S. § 122C-261(f)(4). In so doing, the LME Director shall ensure that every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to the State psychiatric hospital.

7.0 Service Management

7.1 Utilization Management

The LME shall evaluate the necessity, appropriateness and efficiency of health care services for consumers receiving or requesting state funded services against established guidelines and criteria.

7.1.1 Benefit Design

The LME shall adopt and publish during the term of this contract the benefit plan for state-funded target population consumers that define the services that individuals in each target population may expect to receive, including the duration and intensity of such services. The benefit plan shall be flexible to maximize the services that consumers may receive while ensuring the LME delivers services within available funding. Nothing in this contract shall be construed or interpreted as creating an entitlement to state funded services.

7.1.2 Crisis Services

The LME shall provide or arrange for a 24/7/365 crisis response service as mandated by G.S. § 122C-117(a)(14). Upon notification of DHHS approval of the LME local crisis services plan, the LME shall immediately begin to implement such plan. The approved crisis plan shall not be amended without the approval of DHHS.

7.1.3 Person Centered Plan Review

The LME shall review and approve Person Centered Plans (PCP) for consumers receiving State funded services. Additionally, the LME shall review PCPs received from Medicaid providers and shall assess the quality of the plans. This review shall assess the:

(1) Providers' use and implementation of the Person Centered Planning Instruction Manual (July 2007);
(2) Compliance with DHHS policies, procedures, and guidelines;

The LME shall ensure that information regarding the quality and completeness of the plans produced by individual providers is communicated to LME staff responsible for providing technical assistance to providers. LME's may utilize the abbreviated version of the PCP for limited state funded benefits.

7.1.4 Service Authorization

The LME shall authorize state-funded services based upon a properly completed PCP and in accordance with the LME's benefit plan for the consumer's target population. The LME shall respond to properly completed and submitted routine State service authorization requests within 14 calendar days; and urgent requests within 24 hours. Service authorizations shall be considered as a commitment to pay (within agreed upon contract limits) when the service is appropriately rendered and documented.

7.1.5 Consumer Notification of LME Service Authorization Decisions

The LME shall notify consumers when services are denied, reduced or terminated by the LME. This notification shall be in accordance with DHHS processes and procedures and shall advise the consumer of how to exercise their appeal rights regarding the decision.

7.1.6 Post Payment Clinical and Administrative Reviews

The LME shall conduct post-payment reviews of Medicaid and non-Medicaid funded services to ensure that services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Services Definitions Manual; DHHS policies and communications; the Medicaid Provider Enrollment Agreement; the North Carolina General Statutes and the Federal Code of Regulations. As DMA's representative, the LME has the authority and responsibility to make clinical and administrative determinations relating to quality and quantity of services rendered by Providers endorsed by the LME. The LME shall work with DMA to identify high risk or high concern areas in which to conduct Post Payment Reviews (PPR) at a level to be mutually agreed upon. Following completion of the PPR's, the LME shall report its specific findings to the DMA Program Integrity Unit and DHHS using standard referral documents and protocols as follows:

(1) Referrals to DMA Program Integrity require that the LME complete preliminary review of allegations to determine if:
- The allegation can be substantiated
- The actions of the Provider meet the definitions of Provider Abuse found in 10A NCAC 22F.0301 or Provider Fraud found in N.C.G.S. 108-A-63
- The issues identified require actions on the part of DMA to require Provider repayment of Medicaid funds and/or to impose other sanctions or referrals to law enforcement.

(2) The LME shall maintain a log of Provider Cases Referred to DMA Program Integrity. The log shall include, at a minimum, the following information:
- Provider Name
- Provider Medicaid Number
- Nature of Complaint/Issue/Problem
- Name and Phone number of LME Staff Analyst/Investigator for this case
- Date Review Opened
- Date Review Closed
- Findings of Review
- Date Sent to Program Integrity

(3) Any Provider reviews referred to Program Integrity shall be identified by the Provider Name, Provider Medicaid Number (Individual or Group practice), or the Medicaid Provider Federal Tax Identification Number (Corporations consisting of Multiple Individuals or Groups). The referral package shall consist of all original case documents obtained and maintained by the LME as part of their case review. These documents shall minimally include:
- "LME Referral to DMA Program Integrity" cover sheet
- Summary letter by the LME Staff Analyst/Investigator, detailing issues and findings; reasons for referral to Program Integrity, and recommendation for what LME believes to be appropriate sanction/action for this Provider.
- All documents related to this case review including but not limited to:
  - Provider medical/financial records obtained by LME
  - LME generated reports on Provider

- Phone call log/list related to this review
- Endorsement or POC documents used in review
- Letters sent to or received from Provider

The LME shall have the appropriate licensed clinicians and administrative staff involved in clinical decision making available upon request to participate in any appeal process resulting from LME referrals to Program Integrity. The LME shall have the appropriate licensed clinicians or administrative staff available upon request to participate with the department in developing ongoing post-payment review tools and processes to address all enhanced services.

7.1.7 CAP-MR/DD Waiver Requests

The LME shall maintain a list of consumers wishing to be considered for participation in the CAP-MR/DD Waiver. The list shall be prioritized based upon each consumer's acuity of need. When notified by DHHS that additional consumers may be added to the CAP-MR/DD Waiver, the LME shall notify case managers of the most acutely in-need consumers in order to process the eligibility determination requests.

7.2 Care Coordination

7.2.1 Care Coordination for Consumers without a Clinical Home

The LME shall provide care coordination services for consumers who are being discharged from state facilities, hospitals, or emergency services that do not have a connection with a clinical home provider. This includes participating in discharge planning and continuing to work with the consumer and primary care physician until the consumer is connected to a clinical home provider. The LME has the responsibility to ensure that staff is available for participation at the annual Plan of Care meetings for consumers from their catchment area who reside in a Developmental Center and are appropriate for community placement. The LME shall ensure that consumers who are being discharged from state facilities are seen by a community provider within 7 calendar days of discharge. The LME shall ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within 5 calendar days.

7.2.2 Care Coordination for High Cost/High Risk Consumers

The LME shall identify and provide care coordination services for consumers having high cost and/or high need. As defined in GS §122C-115.4 (1),(2), "the definition of a high risk consumer: until such time as the Commission adopts a rule, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months. The definition of a high cost consumer: until such time as the Commission adopts a rule, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group." This includes participating in Person Centered Planning, facilitating appropriate connections to primary health care services through Community Care, the Health Department, or other physical healthcare providers. For children, this responsibility includes participation in Child and Family Teams.

7.2.3 Deaf Services (if applicable)

If the LME serves as host to a regional deaf services coordinator, the coordinator shall work with all LMEs in the designated region to assure appropriate services are available to consumers who are deaf and hard of hearing. These staff may provide direct services to deaf, hard of hearing and deaf-blind consumers in their home catchment area and may, upon request,

provide Diagnostic Assessment, Person Centered Planning, individual/group/family therapy, community support, and consultation/ technical assistance in their region as schedules permit. It is expected that these staff will provide services to providers in their region at no cost other than transportation (when not included in the Medicaid rate).

7.3 Community Collaboration

7. 3.1 Community Relationships

The LME shall establish and maintain effective, collaborative working relationships with other public agencies, health care providers, and human services agencies within their catchment area. These include but are not limited to: Departments of Social Services, Local Health Departments, community hospitals, public schools, law enforcement, courts, Juvenile Court Counselors, Community Care Networks and other primary healthcare providers.

7.3.2 Social Marketing Plan

The LME shall develop and implement a plan to engage in public awareness campaigns designed to reduce the stigma attached to disabilities, increase the visibility of the LME in the community, promote prevention activities and support and encourage the use of evidence-based practices. The plan shall include a component designed to increase competitive employment opportunities for consumers.

7.3.3 Natural and Community Supports

The LME shall work with other public, faith-based, and non-profit organizations to increase the service options available to non-target population individuals and to increase the availability of natural and community supports for all consumers. The LME shall pursue opportunities to increase consumers' access to free or low cost medications, affordable housing, employment and other supports and services.

7.3.4 Emergency Response

The LME shall participate in the development of community response plans and shall work with its providers to ensure adequate capacity to meet the needs of the community in the event of a community-wide disaster or emergency situation.

7.3.5 Development of Housing Opportunities for Consumers

The LME shall work with public housing agencies and private landlords to increase housing opportunities for consumers. If the LME has a Division-funded housing coordinator position, the housing coordinator will work with the Division and DHHS housing staff to increase housing opportunities throughout the region to which the coordinator is assigned.

7.4 System of Care

7.4.1 System of Care Coordinator

The LME shall have at least 1.0 FTE staff member fully dedicated to System of Care Coordination. This person(s) is staff to the Community Collaborative comprised of families, child, youth and family serving agencies and community partners; ensures fidelity to the process of Child and Family Teams for Person-Centered Planning; provides System of Care training and

technical assistance to the provider community; and, with local collaboratives, identifies and tracks outcomes to ensure the effectiveness of System of Care efforts.

7.4.2 School-Based Child and Family Teams (if applicable)

If the LME's catchment area includes one or more school districts participating in the Governor's School-Based Child and Family Teams initiative, the LME shall name one staff clinician to serve as the liaison to those teams.

7.4.3 Community Collaborative

The LME shall support a community collaborative comprised of: (1) family members of a child or youth being served; (2) child, youth and family serving public and private agencies; and (3) community partners to support System of Care practices and principles of family-driven and youth-guided care, individualized and community-based services, interagency collaboration, and cultural competence.

8.0 Consumer Affairs and Customer Service

8.1 Supports to CFAC and the Human Rights Committee

The LME shall provide required competent, qualified staff and support to the CFAC and Human Rights Committees to fulfill the functions of these committees.

8.2 Consumer and Family Outreach and Education

The LME shall provide outreach, education and customer service to consumers and families on issues such as rights protection, complaint processes, advocacy and empowerment opportunities, evidence-based practices and service authorization guidelines. The LME shall publicize the priority for admission to a program for injection drug users and substance-abusing pregnant women.

8.3 Assistance to Consumers

The LME shall develop and maintain a Consumer Manual that assists consumers to understand the various parties in the public system, their roles and responsibilities. The LME shall provide assistance to consumers and families in understanding the public delivery system and other public agencies. The LME shall encourage consumer self-advocacy. The LME shall promote the growth of consumer owned and staffed businesses. The LME shall maintain, publish and staff a toll free customer service line during normal business hours.

8.4 Consumer Complaints and Appeals

The LME shall respond to complaints and process appeals from consumers in accordance with state rules and DHHS processes and procedures. The LME shall report all required information regarding critical incidents and consumer complaints and appeals to DHHS in the manner and timeframes outlined in policy and shall report aggregate information on incidents, complaints and appeals to the Board and CFAC quarterly. If a satisfactory outcome is not reached with the LME, the consumer may also appeal (122C-151.4) to the MH/DD/SA appeals Panel.

9.0 Quality Management

9.1 Identification and Remediation of Problems

The LME shall have a process for timely identification and response to consumer incidents and stakeholder complaints about service access or quality.

9.2 Management Reports

The LME shall produce reports referenced in Attachment II 2.0 and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends related to consumers, providers, and LME operations, including but not limited to:

(1) Consumer trends: incidents, client rights, outcomes, use of state facilities, use of emergency services and hospital emergency departments (as provided by DHHS), service utilization rates, and perceptions of care;
(2) Provider trends: service capacity, assessments of provider quality, results of audits and monitoring activities, technical assistance and trainings, and use of evidence-based practices;
(3) LME operations: management of state funds, trends in volume and cost of services per consumer, Screening, Triage, and Referral processes, response to consumer requests for service, complaint response, and choice of providers.

9.3 Consumer Data

The LME shall ensure that its providers collect and submit complete information on consumers, as required by DHHS policy, in a timely manner. The LME shall provide information and support to its providers to encourage their use of data collected by the LME and DHHS for improvement of service quality.

9.4 Quality Improvement

The LME shall establish a quality management committee to identify and address opportunities for improvement of LME operations and the local service system. The committee will have a process for reviewing and incorporating trends (identified in Section 9.2 above) and input from providers, consumers, family members, and other stakeholders into its decisions. The LME shall conduct and report annually on a minimum of three (3) quality improvement studies. The summaries of these studies shall be provided to DHHS, the local Board and the local CFAC.

ATTACHMENT II
Performance Expectations

1.0 Process for Monitoring and Reporting of Local System Quality and Compliance

1.1 Quarterly Report on Performance

The DHHS shall evaluate the overall performance of the LME system through review of each management function and through statewide measures of service quality, as described in this Attachment. The DHHS shall calculate and publish quarterly the LME's performance on each indicator listed in Sections 3.0 through 5.0 below.

1.2 Correction of Published Errors

If the LME believes information in the publication to be erroneous, the LME shall contact the designated DHHS representative (LME Liaison) within 30 days of the publication of data on the above indicators to request a data review. The LME shall provide evidence to support the LME's request and to assist the DHHS to make a determination concerning the request.

The DHHS shall provide a written response to the LME within 30 days of receiving the LME's request. If the DHHS agrees to correct the error, the DHHS response shall provide details concerning the error and revision. The DHHS will publish a revised report with the corrected data, when an error is determined to be the responsibility of the DHHS.

2.0 Summary of Functional Components

The DHHS will monitor the LME's implementation of each management function on an ongoing basis. A fully functioning LME shall have in place all of the components of each management function listed in the table below. The DHHS shall use the essential components (in bold) to evaluate the LME's performance of each function. The items in bold italics have implications for retention of Medicaid funding.

Function	Components
General Administration and Governance	(1) Active Board that meets at least (6) times a year; (Attachment I 1.2) (2) **Active CFAC that meets at least six (6) times a year; (Attachment I, 1.3)** (3) **Qualified CEO that meets required qualifications per NCGS 122C-121(d); (Attachment I, 1.4)** (4) Satisfaction of SPMP (FFP) requirements; (Attachment I, 1.5) (5) ***Qualified clinical staff in all three disability areas (Attachment I, 1.5)***
Business Management and Accounting	(1) Management of IPRS funds to reimburse providers for authorized, delivered, and billed services; (Attachment I, 2.1) (2) Quarterly written reports including a balance sheet provided to the Board and CFAC (Attachment I, 1.2 & 2.2) (3) **Standardized statewide contract with all providers of state-funded services and standardized MOA with all endorsed Medicaid providers; (Attachment I, 2.3)** (4) Submission of Reports to DHHS as required; (Contract 10.0 (6)

Function	Components
Information Management	(1) **Fully functioning IT infrastructure, HIPAA compliant, electronic connection to State IT, and capability to communicate with providers electronically; (Attachment I, 3.1)** (2) **Submission of consumer screening, admissions, and eligibility data (Attachment I, 3.2)** (3) **Analysis of services authorizations and claims data; (Attachment I, 3.3)** (4) Timely response to data requests; (Contract 10.0 (6) (5) **Informative, user-friendly website with current (evergreen) information. (Attachment I, 3.4)**
Claims Processing	(1) **Process for prompt payment of claims; (Attachment I, 4.1)** (2) **Process to identify all relevant payer information for each consumer**; **(Attachment I, 4.1)** (3) Process to pursue all applicable first and third party payments for services; (Attachment I, 4.2) (4) Identification of all payer information for each consumer (Attachment I, 4.2)
Provider Relations	(1) Annual assessment of community need and provider capacity and quarterly updates reported to Board & CFAC; (Attachment I, 5.1) (2) ***Minimum number of provider agencies for every service necessary to ensure consumer choice; (Attachment I, 5.2)*** (3) ***Process for timely endorsement and enforcement of endorsement requirements; (Attachment I, 5.4)*** (4) Appropriate provider manual, trainings and technical assistance; (Attachment I, 5.3 & 5.6) (5) ***Process for ongoing evaluation and monitoring of provider quality and compliance with data submission requirements; (Attachment I, 5.5)*** (6) Process for resolving provider complaints. (Attachment I, 5.7)
Access / Screening, Triage and Referral	(1) ***Toll-free phone line; (Attachment I, 6.1)*** (2) ***24-hour access 365 days a year; (Attachment I, 6.1)*** (3) ***Calls answered within 30 seconds by trained staff; (Attachment I, 6.1)*** (4) ***TTY and Relay capability and Spanish-language interpreter; (Attachment I, 6.1)*** (5) ***Ability to schedule appointments with an appropriate provider within 24 hours of initial contact; (Attachment I, 6.1)*** (6) Process for managing DHHS bed-day allocations; (Attachment I, 6.4) (7) Report to Board and CFAC on access patterns and trends; (Attachment I, 1.2) (8) Screening consumers using the standard state form or all of the elements of the standard from. (Attachment I, 6.2)

Function	Components
Service Management (UM, Care Coordination, Community Collaboration, and SOC)	(1) Published State-Funded Consumer Benefit Plan; (Attachment I, 7.1.1) (2) **Implementation of approved LME crisis services plan; (Attachment I, 7.1.2)** (3) Process for review of person-centered plans; (Attachment I, 7.1.3) (4) **Service authorization decisions within required timelines; (Attachment I, 7.1.4)** (5) **Notification to consumers of rights and appeals regarding LME service authorization decisions; (Attachment I, 7.1.5)** (6) ***Audit and Post-payment review of services by licensed staff*; (*Attachment I, 7.1.6)*** (7) ***Management and prioritization of requests for CAP-MR/DD Waiver services; (Attachment I, 7.1.7)*** (8) **Coordination of care for high cost/high risk consumers and consumers without a clinical home; (Attachment I, 7.2.1 & 7.2.2)** (9) **Active collaborative relationships with other human service agencies**; **(Attachment I, 7.3.1 & 7.4.3)** (10) Activities to encourage use of natural and community supports; (Attachment I, 7.3.3) (11) Full-time System of Care coordinator; (Attachment I, 7.4.1) (12) Designated staff to coordinate deaf services, school-based child and family teams, and development of housing opportunities (if applicable); (Attachment I, 7.2.3 & 7.3.5 & 7.4.2) (13) Quarterly Report to the Board on service utilization patterns. (Attachment I, 1.2 & 8.4)
Consumer Affairs and Customer Service	(1) **Customer service phone line answered during business hours by live staff; (Attachment I, 8.3)** (2) Outreach/education activities and materials (English & Spanish); (Attachment I, 8.2) (3) **Consumer Manual**; **(Attachment I, 8.3)** (4) Timely response and resolution (disposition) to consumer questions and complaints; (Attachment I, 8.4) (5) Staff support to the CFAC and Client Rights Committees; (Attachment I, 8.1) (6) Report to Board and CFAC on consumer incidents, complaints, appeals, and satisfaction with services at least quarterly. (Attachment I, 1.2 & 8.4)

Function	Components
Quality Management	(1) **Timely identification and remediation of problems; (Attachment I, 9.1)** (2) Production and review of regular management reports; (Attachment I, 9.2) (3) **Collection and submission of consumer data; (Attachment I, 9.3)** (4) **Analysis and use of data for planning, decision making and improvement; (Attachment I, 9.4)** (5) Active Quality Improvement committee; (Attachment I, 9.4) (6) Report on QI activities to Board and CFAC quarterly and to DHHS annually. (Attachment I, 1.2 & 9.4)

3.0 Clinical Performance Indicators

DHHS will use the following measures to monitor the LME's performance on functional areas that have a direct impact on consumer care. DHHS will review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME's performance. Results will be published quarterly, as described in Section 1.0 of this Attachment.

A standard for expected performance is assigned to each measure. DHHS will use performance below the expected level on one or more measures as a signal that further on-site review of the LME's functions may be needed. A target for improvement to be achieved by the end of the contract period is also assigned to each measure. Targets are set higher for areas where DHHS is focusing statewide improvement efforts during the contract period.

3.1 Timely Access to Care Indicator

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.

3.1.1 Timely Emergent Care

SFY 2008 Performance Standard: 100% of persons in crisis receive face-to-face emergency care within no more than two hours after the request for care is initiated.

SFY 2008 Target: Achievement and maintenance of most current annual state average at 100%.

Measurement:
The DHHS will compare quarterly each new consumer's date and time of screening to the consumer's time of service initiation, as submitted to the Consumer Data Warehouse (CDW) by the LME, to determine the total number of persons that are determined to need emergent care and, of those, the percent who have their first face-to-face urgent care within one hour and within 2 hours of the request. The DHHS will reconcile data submitted to the Consumer Data Warehouse (CDW) by the LME and the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim.

3.1.2 Timely Urgent Care

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q4 SFY2006 – Q3 SFY 2007) of 80%

SFY 2008 Target: By June 30, 2008, the percent of persons in urgent need of mh/dd/sa services who receive their first face-to-face service (assessment and/or treatment) within 48 hours of the request for care increases by 10% over the most current annual state average from 80% to 88%.

Measurement:
The DHHS will compare quarterly each new consumer's date of screening, as submitted to the Consumer Data Warehouse (CDW) by the LME, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the total number of persons that are determined to need urgent care and, of those, the percent who have their first face-to-face urgent care within 48 hours of the request.

3.1.3 Timely Routine Care

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q4 SFY2006 – Q3 SFY 2007) of 63%

SFY 2008 Target: By June 30, 2008, the percent of persons eligible for routine mh/dd/sa services who receive their first face-to-face service (assessment and/or treatment) within 10 working days (14 calendar days) of the date of the request for care increases by 10% over the most current annual state average from 63% to 69%.

Measurement:
The DHHS will compare quarterly each new consumer's date of screening, as submitted to the Consumer Data Warehouse (CDW) by the LME, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the total number of persons that are determined to need routine care and, of those, the percent who have their first face-to-face routine care within 14 calendar days of the request.

4.0 Provider Relations Indicator

4.1 Treated Prevalence Indicator

Rationale: The public system is charged with serving all NC residents who have inadequate personal resources and are in need of specialized mh/dd/sa services, commensurate with available resources. Because services to persons with substance abuse services have declined substantially over recent years, the DHHS is setting a priority of increasing services to these individuals.

Measurement:
DHHS will analyze CDW admissions and IPRS and Medicaid service claims data quarterly to determine the number of persons in each age-disability group who received at least one mental health service in the past four quarters. Treated prevalence will be calculated as the number of persons in the group served divided by the national prevalence estimate, as determined below.

4.1.1 Adult Mental Health (AMH) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 38%

SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving AMH services at the most current annual state average of 38%.

Prevalence Estimate:
A national prevalence estimate for North Carolina is determined by the federal Center for Mental Health Services annually. The most recent statewide prevalence estimate (for FFY 2005) is that 5.4% of adults ages 18 and above have a serious mental illness in any given year.

4.1.2 Child/Adolescent Mental Health (CMH) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 38%

SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving CMH services at the most current annual state average of 38%.

Prevalence Estimate:
According to the most recent national prevalence estimate, as determined by the federal Center for Mental Health Services for FFY2005, 12% of children and adolescents ages 0-17 have a serious emotional disturbance in a given year. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

4.1.3 Adult Developmental Disability (ADD) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 36%

SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving ADD services at the most current annual state average of 36%.

Prevalence Estimate:
The national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 0.79% of adults ages 18 and above have a developmental disability.

4.1.4 Child/Adolescent Developmental Disability (CDD) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 19%.

SFY 2008 Target: By June 30, 2008 the LME shall reach or exceed the percent of persons receiving CDD services at the most current annual state average of 19%.

Prevalence Estimate:
The national prevalence estimate, as determined by the 1994-1995 National Health Interview Survey, is that 3.21% of children and adolescents ages 0-17 have a developmental disability. Because the NC public health system is responsible for serving children from birth through age 2, the prevalence estimate will be applied to the LME's population ages 3-17.

4.1.5 Adult Substance Abuse (ASA) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 8%.

SFY 2008 Target: By June 30, 2008 the percent of persons receiving ASA services increases by 25% over the most current annual state average from 8% to 10%.

Prevalence Estimate:
The national prevalence estimate for North Carolina, as determined by the 2003-2004 National Survey of Drug Use and Health, is that 7.98% of adults ages 18 and above have a substance abuse problem in any given year.

4.1.6 Adolescent Substance Abuse (CSA) Services

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 7%.

SFY 2008 Target: By June 30, 2008 the percent of persons receiving CSA services increases by 25% over the most current annual state average from 7% to 9%.

Prevalence Estimate:
The national prevalence estimate for North Carolina, as determined by the 2003-2004 National Survey of Drug Use and Health, is that 7.24% of adolescents ages 12-17 have a substance abuse problem in any given year.

5.0 Service Management Indicators

5.1 Timely Initiation of Service Indicator

Rationale: Timely initiation of appropriate, ongoing service is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. This is a Washington Circle Public Sector Workgroup measure, supported by SAMHSA.

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q1 SFY 2007) for each disability group.

SFY 2008 Target: By June 30, 2008 the percent of persons beginning mh/dd/sa services who have at least two services within the first 14 calendar days of care increases by 20% over the most current state average.

Measurement:
The DHHS will calculate quarterly the time between the first and second service events (assessment and/or treatment) for each new consumer, based on IPRS and/or Medicaid paid service claims data, to determine the percent of new consumers who received at least two services in the first 14 calendar days of care. A new consumer is defined as a consumer who has not received any state- or federally-funded service for at least 60 days, excluding persons in the AMSRE target population.

5.1.1 Persons Receiving Mental Health Services
(Standard = 35%; Target = 42%)

5.1.2 Persons Receiving Developmental Disability Services and Supports
(Standard = 60%; Target = 72%)

5.1.3 Persons Receiving Substance Abuse Services
(Standard = 59%; Target = 71%)

5.2 Timely Engagement in Service Indicator

Rationale: Timely continuation of appropriate service is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. This is a Washington Circle Public Sector Workgroup measure, supported by SAMHSA.

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q1 SFY 2007) for each disability group.

SFY 2008 Target: By June 30, 2008 the percent of persons who have at least two services within the 30 calendar days following their second service increases by 20% over the most current state average.

Measurement:
The DHHS will calculate quarterly the time between the second and fourth service events (assessment and/or treatment) for each consumer who received a second service within the first 14 days of care (i.e. consumers who met the standard for Measure 1.3), based on IPRS and/or Medicaid paid service claims data, to determine the percent of new consumers who received at least two additional services in the next 30 calendar days of care. A new consumer is defined as a consumer who has not received any state- or federally-funded service for at least 60 days, excluding persons in the AMSRE target population.

5.2.1 Persons Receiving Mental Health Services
(Standard = 21%; Target = 25%)

5.2.2 Persons Receiving Developmental Disability Services and Supports
(Standard = 46%; Target = 55%)

5.2.3 Persons Receiving Substance Abuse Services
(Standard = 42%; Target = 50%)

5.3 State Psychiatric Hospital Use Indicators

5.3.1 Short-Term State Psychiatric Hospital Use Indicator

Rationale: Serving individuals in need of short-term crisis services in their home communities and in the least restrictive setting appropriate helps families to stay in touch and reserves high-cost state psychiatric hospital beds for individuals in need of long-term care. This is a Mental Health Block Grant measure required by the Center for Mental Health Services.

SFY 2008 Performance Standard: Achievement and maintenance of the most current state average (Q2 – Q3 SFY 2007) of 55%

SFY 2008 Target: By June 30, 2008 the percent of persons admitted to state psychiatric hospitals each quarter who have stays of 7 days or less decreases by 20% from the most current state average from 55% to 44%.

Measurement:
The DHHS will calculate the lengths of stay of individuals discharged from a state psychiatric hospital each quarter, as recorded in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) to determine the number of individuals with lengths of stay of 1-7 days as a percent of total discharged individuals for the quarter.

5.3.2 Psychiatric Hospital Readmissions

Rationale: Individuals who receive appropriate community-based services, especially following inpatient care, will experience fewer crises and attain a more stable recovery. An individualized crisis plan, developed through person-centered planning, can help to prevent crises and ensure that crises that do arise can be addressed without further hospitalization. This is a Mental Health Block Grant measure required by the Center for Mental Health Services.

5.3.2.1 Hospital Readmissions within 30 Days

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q4 SFY2006 – Q3 SFY 2007) of 9%.

SFY 2008 Target: By June 30, 2008 the percent of persons readmitted to state psychiatric hospitals within 1-30 days of discharge decreases by 10% from the most current state average from 9% to 8%.

Measurement:
The DHHS will calculate the number of individuals readmitted to a state psychiatric hospital within 1-30 days as a percent of individuals discharged from a state psychiatric hospital each quarter, as recorded in HEARTS.

5.3.2.2 Hospital Readmissions within 180 Days

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q4 SFY2006 – Q3 SFY 2007) of 18%

SFY 2008 Target: By June 30, 2008 the percent of persons readmitted to state psychiatric hospitals within 1-180 days of discharge decreases by 10% from the most current state average from 18% to 16%.

Measurement:
The DHHS will calculate the number of individuals readmitted to a state psychiatric hospital within 1-180 days as a percent of individuals discharged from a state psychiatric hospital each quarter, as recorded in HEARTS.

5.4 Continuity of Care after State-Operated Inpatient Services Indicator

Rationale: Timely follow-up care is critical to minimize adverse consumer outcomes, prevent the need for re-hospitalization, and promote recovery.

5.4.1 Follow-Up after Discharge from a State Psychiatric Hospital

SFY 2008 Performance Standard: Achievement and maintenance of the most current state average (Q4 SFY2006 – Q1 SFY 2007) of 28%

SFY 2008 Target: By June 30, 2008, the percent of persons discharged from a state psychiatric hospital who receive follow-up care in the community within 7 calendar days of discharge increases by 50% over the most current state average from 28% to 42%.

Measurement:
The DHHS will compare quarterly each consumer's date of discharge from a state psychiatric hospital, as recorded in HEARTS, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the number of persons receiving a community-based service within 7 days of discharge as a percent of all persons discharged during the quarter.

5.4.2 Follow-Up after Discharge from a State Alcohol and Drug Abuse Treatment Center

SFY 2008 Performance Standard: Achievement and maintenance of the most current state average (Q4 SFY2006 – Q1 SFY 2007) of 24%

SFY 2008 Target: By June 30, 2008, the percent of persons discharged from a state alcohol and drug abuse treatment center (ADATC) who receive follow-up care in the community within 7 calendar days of discharge increases by 50% over the most current state average from 24% to 36%.

Measurement:
The DHHS will compare quarterly each consumer's date of discharge from a state ADATC, as recorded in HEARTS, to the consumer's first date of service (assessment and/or treatment) paid through an Integrated Payment & Reporting System (IPRS) and/or Medicaid service claim to determine the number of persons receiving a community-based service within 7 days of discharge as a percent of all persons discharged during the quarter.

5.5 Child Services in Family Settings

Rationale: Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.

SFY 2008 Performance Standard: Achievement and maintenance of the most current annual state average (Q3 SFY2006 – Q2 SFY 2007) of 6%.

SFY 2008 Target: By June 30, 2008, the percent of children who receive mh/dd/sa services in residential settings will decrease by 10% over the most current state average from 6% to 5%.

Measurement:
The DHHS will calculate the number of children receiving Level II (Program Type only), Level III and/or Level IV residential services each quarter, according to Integrated Payment & Reporting System (IPRS) and/or Medicaid service claims, as a percent of all children served by the LME.

Attachment III
FINANCING

1.0 Systems Management Funding

The LME shall be paid a monthly Systems Management payment based on the modeled costs of the System Management functions listed in this section. The payment is based upon the cost that should be predicted for an efficient Systems Manager.

The Systems Management payment will be funded entirely by the Department. If a county chooses to provide additional funding for Systems Management functions, such additional funding must be in addition to the funding required of counties by G.S. 122C-115.

The Systems Management payment will cover the following LME functions which are more fully described in the Scope of Work.

(1) General Administration and Governance;
(2) Business Management and Accounting;
(3) Information Management Analysis and Reporting;
(4) Claims Processing;
(5) Provider Relations and Support;
(6) Access, Screening, Triage and Referral;
(7) Service Management (Utilization Management, Service Coordination and Community Collaboration);
(8) Consumer Affairs and Customer service;
(9) Quality Improvement and Outcomes Evaluation.

The Systems Management LME payment will be subject to a year-end reconciliation process based upon monthly reporting by the LME to ensure that Medicaid funds have not been paid in excess of actual cost. Medicaid regulations, Medicaid State Plan, Attachment 4.19-B, Section 13 limit federal financial participation to actual cost in public agencies. If a reconciliation of expenditures determines that any reported expenditures were non-allowable for both Medicaid and State funds, an adjustment will be made to the subsequent monthly payment. The DHHS Cost Allocation Plan for LME Systems Management payments assumes that certain functions are performed by staff that qualify for 75% federal financial participation (FFP) as a result of their status as a Skilled Professional Medical Personnel (SPMP). If DHHS is unable to claim the anticipated level of Medicaid FFP due to actions of the LME, such as not employing staff that meet SPMP qualifications or contracting out SPMP functions to a non-governmental agency, the LME's Systems Management payments will be reduced in an amount equal to the unearned Medicaid FFP. Any State funds paid in excess of actual cost will be subject to repayment, except that the LME may retain state funds paid in excess of expenditures in an amount not to exceed the lesser of 15% of the LME's total allowable Service Management expenditures or 15% of the LME's total allocation for Service Management payments.

2.0 Services Funding

The Department shall provide the LME with an annual allocation of State and federal funds for mental health, developmental disabilities and substance abuse services to non-Medicaid eligible consumers and for non-Medicaid services. Allocations shall be designated as Unit Cost Reimbursement (UCR) or non-UCR. UCR allocations shall be earned through IPRS (Integrated

Payment and Reporting System). Non-UCR expenditures shall be paid and settled in accordance with the DHHS Cash Management Plan and procedures established and conducted by the DHHS Office of the Controller. All expenditures from state allocated services funds shall be for the benefit of consumers identified as meeting the target population categories outlined by DHHS.

3.0 Single Stream Funding

An LME that is approved by DHHS to receive single-stream funding shall continue to enroll individuals into the appropriate population group and to report service units to the Integrated Payment and Reporting System (IPRS). Reporting to IPRS shall contain accurate and complete content to allow either (a) claims payment through the appropriate source of Federal funds not included in single-stream funding or (b) processing of claims until a 'budget/fiscal deny [EOB 8505]' is received by the LME for insufficient budget.

Except as noted herein, an LME that receives single-stream funding shall use Division funding only to purchase services included in the IPRS service array. If the LME desires to provide services not included in the IPRS service array, the LME must contact the DHHS' DMH/DD/SAS Budget and Finance Team to develop a reporting code and appropriate rate for the approved new service.

Each LME receiving single stream funding shall meet or exceed the Division designated Maintenance of Effort (MOE) requirements for state only funding by LME for SFY 07-08 in accordance with the Division's federal mandates in the current applicable Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Mental Health Block Grant (MHBG). The MOE requirement for SFY 08 is defined as the amount of State funding allocated in SFY 07, with adjustments in State funding, including any increases or decreases, for SFY 08.

Required expenditures by LME of state appropriated funds for substance abuse treatment services shall be reported in IPRS and shall fully address both the overall SAPTBG MOE for substance abuse treatment expenditures and the Women's MOE for substance abuse treatment expenditures for pregnant women and women with dependent children.

Required expenditures by LME of state appropriated funds for mental health treatment services shall be reported in IPRS and shall fully address both the overall MHBG MOE for mental health treatment expenditures and the Child Mental Health Services MOE for mental health treatment expenditures for children and adolescents under the age of 18.

Year-end settlement of Division allocated funds paid to the LME via the single stream 1/12th methodology shall be as follows:

a. If the value of allowable shadow claims submitted through IPRS are equal to or exceed the total single stream funding payments for the year, no refund shall be due to the Division by the LME;
b. In the event the value of allowable IPRS shadow claims are not equal to or greater than Division single stream payments noted above, the LME may provide supplemental information on allowable documented actual expenditures, including but not limited to program specific non-UCR payments, which do not duplicate the value of allowable shadow claims. If the total value of the LME's allowable IPRS shadow claims plus the LME's documented and Division approved actual expenditures are equal to or greater than Division single stream payments noted above, no refund shall be due to the Division by the LME.
c. If, after determining the utilization of Division funds as set forth in item b. above, the total value of services is less than the amount paid to the LME in Division single stream

payments noted above, the LME shall refund the difference to the Division, minus up to 15% of the total allocation to be retained in the subsequent fiscal year for service provision.

d. For the purpose of settlement, an allowable IPRS shadow claim is defined as an IPRS claim which processes to render a budget/fiscal deny [EOB 8505].

4.0 Reservation of Funds for Utilization in Subsequent Fiscal Years

4.0.1 This section applies only to multi-county LMEs and not single county programs.

4.0.2 Funds otherwise required to be reserved by North Carolina General Statutes or as otherwise determined by the independent auditor, do not require prior approval from DHHS and are not impacted by items 4.0.3 and 4.0.4 below.

4.0.3 The portion of fund balance that is designated by the Area Board may be excluded in the DHHS determination of the 15% unrestricted fund balance. To be excluded, such designation must first be approved by the Area Board and then the LME must have secured approval from DHHS for the designation. Prior approval is to be requested in writing to the Division's Budget and Finance Team Leader and, after consultation with the DHHS Office of the Controller, the Division will respond in writing to the LME within thirty (30) days after receipt of the request. At a minimum, requests submitted by LMEs to the Division shall include: (i) amount of funds requested for designation by purpose, (ii) a detailed justification for the proposed utilization of the funds requested for designation by purpose, including a timetable for expending the designated funds, (iii) impact analysis, by purpose, if the request(s) to designate funds is not approved by DHHS, and (iv) copy of the LME Board minutes which reflect the Board's approval to request the designation of such funds. Such requests for designation must be submitted to the Division prior to the June 15 of the year in which the funds are available for designation to allow review and action prior to fund balance computations for the year.

4.0.4 In the event the unrestricted fund balance for any year is in excess of the fifteen percent (15%) which the LME may retain, the fund balance amount above 15% is to be handled in accordance with 10A NCAC 27A .0111.

5.0 Disallowances

Any funds or part thereof transferred by DHHS to the LME shall be subject to reimbursement by the LME to DHHS in the event those funds are disallowed pursuant to a State or federal audit.

Attachment IV

DATA USE AGREEMENT

This Data Use Agreement ("DUA") between the North Carolina Department of Health and Human Services ("Department") and the Local Management Entity ("LME") whose name is printed at the end of this DUA shall be effective from and after the date of its execution by both parties and shall remain in effect throughout the term of the Master Agreement to which it is attached, including any option years.

WHEREAS, N.C. Gen. Stat. § 122C-115.4(a) provides that "Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources";

WHEREAS, the statutory functions of the LME include screening, triage and referral, utilization management, care coordination, and financial accountability and management;

WHEREAS, the Department and the LME agree that the LME needs access to certain mental health, developmental disability and substance abuse paid claims data compiled by the Department in order for the LME to perform the duties assigned to it by N.C. Gen. Stat. § 122C-115.4;

WHEREAS, the Department and the LME each represents to the other that it is a "Covered Entity", as that term is defined by the 45 CFR § 160.103;

WHEREAS, the Parties believe that the disclosures described by this Attachment are properly made for the purpose of "Health Care Operations," pursuant to 45 CFR § 164.506(c)(4) and paragraph (1) of the definition of "Health Care Operations" in 45 CFR § 164.501;

NOW THEREFORE, the Parties agree as follows:

1. The Department shall provide the LME with the mental health, developmental disability, and substance abuse Medicaid paid claims data described in Attachments A and B to this DUA.

2. The paid claims data provided to the LME shall be limited to data that pertains to:

    a. Eligible recipients whose county of eligibility lies within the LME's catchment area; and

    b. Eligible recipients whose county of eligibility lies outside of the LME's catchment area who nonetheless receive services from providers located within the LME's catchment area.

3. The mental health and developmental disability paid claims data provided to the LME shall include individually identifiable health information, as defined in 45 CFR § 160.103;

4. The substance abuse paid claims data provided to the LME shall not include individually identifiable health information.

5. The LME shall use the data solely for the following purposes:

a. To fulfill the LME's statutory obligations as outlined in N.C. Gen. Stat. § 122C-115.4, which holds the LME "responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services within a specified geographic area . . . ."
b. To know which providers are serving as the "clinical home" provider and which are actively treating a consumer to facilitate care coordination and improve access to urgent and emergent services;
c. To assess the demand for services in planning for provider-community development activities;
d. To verify that treatment follow-up occurred when the consumer was screened by or through the LME;
e. To conduct retroactive reviews of services delivered to ascertain whether appropriate treatment is being delivered;
f. To review high cost, high need consumers' plans against claims data to determine the appropriateness and effectiveness of the plan;
g. To track the location of children placed in residential services;
h. To ensure that LME care-coordination and provider-relations staff know which providers are involved in which consumers' care;
i. To perform risk assessments that take into account the number of consumers a provider is serving. (Heavier caseloads equal greater potential risk, which may require more rigorous monitoring);
j. To coordinate Medicaid recipients' plans of care when they receive both Medicaid services and State-funded services;
k. To coordinate services with other public agencies, such as the Department of Public Instruction, the Division of Social Services, and the court system;
l. To assess, monitor, and manage hospital utilization by consumers of mental health and substance abuse services;
m. To measure utilization patterns of service delivery against authorizations made by individuals or vendors performing utilization review functions on behalf of the Department;
n. To ascertain whether consumers are receiving basic benefit Medicaid services independently of their State-funded enhanced services;
o. To inform quality management staff of which consumers have been served by a given provider in order to schedule random reviews of client charts as required for monitoring and endorsement activities;
p. To assure providers' compliance with mandatory client-specific outcome reporting requirements, in particular the MHSIP Consumer Satisfaction Survey and NC-TOPPS;
q. To monitor providers' compliance with Medicaid enrollment requirements by verifying the physical location from which services to consumers in the LME catchment area are delivered;
r. To monitor providers' compliance with Medicaid billing and documentation requirements and to notify the Department when a provider fails to substantially comply with such requirements; and
s. To monitor providers to determine whether or not the provider continues to satisfy the requirements for LME endorsement and to notify the DMH/DA/SAS if the LME believes a provider's endorsement should be withdrawn.

6. The LME agrees that it shall not use or disclose the data for any purposes not described in paragraph 5 of this Amendment unless the LME first obtains the Department's prior consent for the use or disclosure pursuant to the DHHS Privacy and Security Policies in effect at the time of the use or disclosure.

7. The Department may suspend or revoke this Attachment, with or without notice, if it discovers that the LME has used or disclosed the data for any unauthorized purpose or that the LME has failed to protect the data in the manner prescribed in 45 CFR Parts 160, 162, and 164 or any other applicable law or regulation.

ATTACHMENT IV
Part A

Mental Health and Developmental Disability Medical Paid Claims Data
To Be Provided By The Department To The LME

A. An LME Monthly Medicaid Claims File for paid claims (paid>0) for residents of the LME's catchment area, based on the Medicaid county of eligibility, with the following characteristics:

1. Flat ASCII File, with a separate record for each detail paid Medicaid claim processed during the month

2. Posted to Secure FTP site

3. Contains the following information

    a. Client Medicaid Number, Name and DOB
    b. Billing Provider Code and Name
    c. Attending Provider Code and Name
    d. Type of service code and name
    e. Date of Payment
    f. Date of Service
    g. Paid Units
    h. Payment Amount

4. For these billing sources:

    a. Area Billed
    b. Enhanced Services
    c. Child Residential
    d. Direct Enrolled Behavioral Health Outpatient
    e. PRTF
    f. General Hospital with Psych DRG
    g. State Hospital Medicaid
    h. Non-State Psychiatric Hospital
    i. CAP MR/DD
    j. Criteria 5
    k. Direct Enrolled Psychiatrists
    l. State ICR SNF (Special Care/Black Mountain)
    m. ICF MR Community
    n. ICF MR State

ATTACHMENT IV
Part B

Substance Abuse Paid Claims Data
(Including Both Medicaid Claims Data And State-Funded, Non-Medicaid Claims Data)
To Be Provided By The Department To The LME

A. An LME Monthly Medicaid Claims File for paid claims (paid>0) for residents of the LME's catchment area, based on the Medicaid county of eligibility, with the following characteristics:

1. Flat ASCII File, with a separate record for each detail paid Medicaid claim processed during the month

2. Posted to Secure FTP site

3. Contains the following information:

    a. Billing Provider Code and Name
    b. Attending Provider Code and Name
    c. Type of service code and name
    d. Date of Payment
    e. Date of Service
    f. Paid Units
    g. Payment Amount

4. For these billing sources:

    a. Area Billed
    b. Enhanced Services
    c. Child Residential
    d. Direct Enrolled Behavioral Health Outpatient
    e. PRTF
    f. General Hospital with Psych DRG
    g. State Hospital Medicaid
    h. Non-State Psychiatric Hospital
    i. CAP MR/DD
    j. Criteria 5
    k. Direct Enrolled Psychiatrists
    l. State ICR SNF (Special Care/Black Mountain)
    m. ICF MR Community
    n. ICF MR State